LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

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FISCAL IMPACT STATEMENT

LS 6749 **DATE PREPARED:** Mar 6, 2002
BILL NUMBER: SB 228 **BILL AMENDED:** Feb 25, 2002

SUBJECT: Prior Authorization of Drugs under Medicaid and CHIP.

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FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: (Amended) This bill requires the Children's Health Insurance Program (CHIP) Policy Board to study certain children's benefits.

The bill prohibits the use of prior authorization for drugs for certain disorders under Medicaid and the CHIP. The bill also provides that this prohibition does not apply to a formulary or prior authorization program operated by a managed care organization under the Medicaid or CHIP programs.

This bill also establishes procedures to follow for requiring prior authorization for other drugs under the Medicaid and CHIP programs. The bill allows the Office of Medicaid Policy and Planning (OMPP) to place limits on quantities dispensed or the frequency of refills for any covered drug for the purpose of preventing fraud, abuse, waste, overutilization, or inappropriate utilization or to implement disease management. It also establishes a therapeutics committee as a subcommittee of the Drug Utilization Review (DUR) Board and specifies committee membership and terms. The bill gives the DUR Board additional duties. The bill also sets out implementation dates for the preferred drug list. The bill also specifies that a practitioner may prescribe a single source drug that is medically necessary. It also requires formularies that are used by Medicaid managed care organizations to be uniform throughout the state. (The introduced version of this bill was prepared by the Joint Commission on Medicaid Oversight.)

Effective Date: (Amended) Upon passage; July 1, 2002.

Explanation of State Expenditures: (Revised) This bill places into statute certain limitations on prior authorization in the Medicaid fee-for-service and CHIP programs. These limitations are consistent with current practice and, thus, would result in no additional costs to the state.

Preferred Drug List: The bill also establishes a Therapeutics Committee as a subcommittee of the DUR Board. The Committee and Board are to research, develop, and approve a preferred drug list (PDL) at least

two times per year for Medicaid's fee-for-service, PCCM, and CHIP programs. Drugs on the list will not require prior authorization, while drugs not on the list may be subject to prior authorization. OMPP has estimated a *maximum* potential annual expenditure reduction in the Medicaid program of $30 M in state dollars, depending upon what drugs are placed on the list, the therapeutic classes covered by the list, etc. However, the bill also places significant limitations on the both the structure and the process for developing a preferred drug list. These provisions include: (1) practitioners may bypass the PDL when prescribing a single-source covered outpatient drug that the practitioner indicates is medically necessary; (2) the Drug Utilization Review Board may not exclude a drug from the PDL based solely on price; and (3) the exclusion of drugs for HIV/AIDS, hepatitis C, hemophilia, and epilepsy from the PDL and prior authorization process. Although not immediately quantifiable, these limitations would likely significantly reduce the ability of OMPP to utilize the PDL and prior authorization process to achieve the maximum potential savings of $30 M stated above for the fee-for-service and PCCM programs.

Another provision of the bill will also potentially affect expenditures in the Medicaid Risk-Based Managed Care (RBMC) program, although the extent and direction of the impact are not determinable and will depend on a couple of unknown factors. The provision would require the managed care organizations (MCOs) contracting with OMPP to provide services in the RBMC program, if they use an outpatient drug formulary, to utilize the *same* formulary. Establishment and use of a drug formulary is one cost containment tool used by MCOs. The impact on expenditures will depend on: (1) the specific single formulary that will be established in the future for use by the MCOs; (2) the financial arrangements associated with the single formulary and the associated impact on the cost structure of each MCO; and (3) the extent that any cost impact upon the MCOs will at some time in the future be factored into the contract capitation rates negotiated between OMPP and the MCOs. Although the most likely outcome is probably higher costs faced by the MCOs, the nature of the single formulary, yet to be established, and the outcome of future capitation rate negotiations is not determinable.

The bill also contains several provisions that would have a relatively limited fiscal impact on the Medicaid program. These provisions include: (1) a reduction in the size of the Therapeutics Committee used in establishing a preferred drug list; (2) reporting requirements of OMPP to the Select Joint Commission on Medicaid Oversight regarding a PDL and the collection of data reflecting prescribing patterns related to the treatment of children diagnosed with attention deficit disorder and attention deficit hyperactivity disorder; and (3) a requirement that the Children's Health Policy Board study mental health and addiction services in the Children's Health Insurance Program (CHIP). Although these would impact OMPP and the Children's Health Policy Board, the impact would largely be one of additional workload on current staff, or perhaps some reduced expenditures associated with fewer members on the Therapeutics Committee.

Timing of any expenditure reductions will also depend upon the timing of implementation, with full-year expenditure reductions not likely to occur in the first year. Ultimately, the expenditure reductions will depend upon DUR Board and administrative actions.

Expenditures in the Medicaid program are shared, with about 62% of program expenditures reimbursed by the federal government and 38% provided by the state. Expenditures in the CHIP program are reimbursed at an enhanced federal matching rate of about 73%.

Explanation of State Revenues: (Revised) See *Explanation of State Expenditures*, above, regarding federal reimbursements in the federal- and state-funded Medicaid program and in the CHIP program.

Explanation of Local Expenditures:

Explanation of Local Revenues:

State Agencies Affected: OMPP.

Local Agencies Affected:

Information Sources: Melanie Bella, OMPP, 233-4455.